STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
233 RICHMOND STREET
PROVIDENCE, RHODE ISLAND 02903

ORDER AND DECISION (OHIC-2007-10)

Filing by Blue Cross & Blue Shield of Rhode Island for New Non-Group Subscription Rates for Plan 65 Medigap Plans A, B and C, New Non-Group Subscription Rates for Plan 65 Select Plans B, C and L
(Filed August 10, 2007)

This Order and Decision is issued in response to the August 10, 2007 request of Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for approval of a 4.38% rate increase for the Plan 65 Medigap Plan A (except for a -13.0% decrease of the Plan A Surcharge rate), a 6.02% rate increase for Plan 65 Medigap Plans B and C (except for a -11.65% decrease of the Plan C Surcharge rate), a 3.51% rate increase for the Plan 65 Select Plan B, a 9.01% rate increase for the Plan 65 Select Plan C and a 1.68% rate increase for the Plan 65 Select Plan L (hereinafter "the Filing").[1] After full consideration of the Filing, recommendations submitted by my staff and an independent actuary, written comments received by Plan 65 members and the applicable statutes and regulations, the rate increases requested by Blue Cross in the Filing are approved, with the following modifications:

- The physician fee schedule conversion factor should be reduced to 0%; and
- The contribution to surplus should be reduced by 1%.

These modifications will reduce the rates proposed in the Filing by approximately 2%.[2] Blue Cross must recalculate its Plan 65 rates consistent with this Order and Decision and resubmit those rates to this Office within five days of the date of this Order and Decision.

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[1] Blue Cross is eliminating the Surcharge rates for Plans A and C. These rates currently cover only 67 subscribers. Subscribers previously subject to the Surcharge rates will now receive the lower Base rate.

[2] State and federal tax components of the rate must also be adjusted to be consistent with the above modifications.

I. THE REQUESTED RATE INCREASE

The Filing

The Filing requested increases in premiums charged to subscribers who are Medicare beneficiaries and members of non-group Plan 65 Medicare supplement ("Medigap") Plans A, B and C and Plan 65 Medicare supplement Select ("Select") Plans B, C and L. Plan 65 Select plans offer the same coverage as regular Plan 65 Medigap plans but at a lower cost. The lower cost is made possible by restricting certain covered services to a network of participating hospitals and doctors.

The Blue Cross Plan 65 policies supplement Medicare by providing coverage for some of the health care costs that original Medicare does not cover.[3] Blue Cross offers four types of Medicare supplement policies: Plans A, B and C, with a Select variation of the Medigap B, C and L plans. There are approximately 19,500 members of Blue Cross' non-group Plan 65 products.[4]

The Plan 65 rates currently in effect were approved by Office of the Health Insurance Commissioner ("OHIC") on December 14, 2006. The proposed rates in the Filing will be applicable to billing cycle rate years commencing February 1, 2008, March 1, 2008 and April 1, 2008. The proposed rate increases will change the Plan 65 Medigap rates for existing subscribers as follows:[5]

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[3] General information about Medicare supplement policies is available from the federal government at http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

[4] The Medigap Plan C and Select Plan C together have approximately 98% of the membership.

[5] The Discount Rates for Plans A and C are applicable to subscribers who enrolled prior to November 1, 1998 and within six months of their first eligibility for Medicare Part B as their primary insurer. The Base Rates for Medigap Plans A and C are applicable to all new enrollees, those subscribers who enrolled on or after November 1, 1998, and those subscribers who enrolled prior to November 1, 1998 and between six months and five years of first eligibility for Medicare Part B as their primary insurer. The Surcharge Rates for Medigap Plans A and C, which are now discontinued, were applicable to subscribers who enrolled prior to November 1, 1998 and after more than five years

PLAN	PRESENT MONTHLY RATE	PROPOSED MONTHLY RATE	PERCENTAGE INCREASE
Plan A-Discount	$105.72	$110.36	4.38%
Plan A-Base	$117.47	$122.62	4.38%
Plan A-Surcharge	$140.95	$122.62	-13.00%
Plan A-Year 1 Age-in	$82.23	$85.83	4.38%
Plan A-Year 2 Age-in	n/a	$98.10	n/a
Plan B	$111.52	$118.23	6.02%
Plan C-Discount	$164.89	$174.82	6.02%
Plan C-Base	$183.21	$194.24	6.02%
Plan C-Surcharge	$219.85	$194.24	-11.65%
Plan C-Year 1 Age-in	$128.25	$135.97	6.02%
Plan C-Year 2 Age-in	n/a	$155.39	n/a

The proposed increases will change the Plan 65 Select rates for existing subscribers as follows:

PLAN	PRESENT MONTHLY RATE	PROPOSED MONTHLY RATE	PERCENTAGE INCREASE
Select Plan B-Discount	$98.61	$100.21	3.51%
Select Plan B-Standard	$117.69	$121.82	3.51%
Select Plan C-Discount	$114.60	$124.93	9.01%
Select Plan C-Standard	$156.18	$170.25	9.01%
Select Plan C-Year 1 Age-in	$80.22	$87.45	9.01%
Select Plan C-Year 2 Age-in	n/a	$99.94	n/a
Select Plan L-Standard	$100.80	$102.49	1.68%
Select Plan L-Year 1 Age-in	$70.56	$71.74	1.68%
Select Plan L-Year 2 Age-in	n/a	$81.99	n/a

Jurisdiction

The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. This Office has the right to call an evidentiary hearing to further examine issues raised in the Filing. However, upon receipt and examination of the Filing, this Office determined that the Filing presented that no unique or challenging regulatory, actuarial, or public policy issues that would have been best addressed in the context of an evidentiary hearing. Accordingly, no hearing was held. Notice of the rate increase was

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of first eligibility for Medicare Part B as their primary insurer. Blue Cross discontinued the use of "point-of-entry" rating for Medigap Plans A and C for all new subscribers enrolling after November 1, 1998. Subscribers who had "point-of-entry" rates as of November 1, 1998 continue to have the Discount Rates since this rating system was intended to be in effect for the lifetime of the subscriber.

published in the Providence Journal on September 18, 2007 and Blue Cross' filing was posted on the OHIC web site. Written public comment was solicited and the Office received four responses.

Standard of Review

The rates requested by Blue Cross must be "consistent with the proper conduct of the applicant's business and with the interest of the public . . . ."[6] The OHIC may approve, disapprove, or modify the rates proposed by Blue Cross.[7]

In 2004 the Rhode Island General Assembly established the meaning of "proper conduct of the applicant's business" with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*[8] They decreed that Blue Cross' mission includes providing "affordable and accessible health insurance to insureds"[9] and "affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals."[10] The Board of Directors was specifically charged with "ensuring that the corporation effectively carries out the charitable mission for which it was incorporated . . . ."[11] Under the new law, Blue Cross must also "employ pricing strategies that enhance the affordability of health care coverage . . . ."[12] These legislative directives make clear that the "proper conduct of the applicant's business" is no longer left solely to the management's discretion unless that discretion is exercised to provide

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[6] R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

[7] Id.

[8] See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd, Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

[9] R.I. Gen. Laws § 27-19.2-3(1).

[10] R.I. Gen. Laws § 27-19.2-3(5).

[11] R.I. Gen. Laws § 27-19.2-4(b).

[12] R.I. Gen. Laws § 27-19.2-10(3).

"affordable" and "accessible" health insurance.[13]

II. ANALYSIS

Medicare Physician Fee Schedule Conversion Factor

The Medicare physician fee schedule conversion factor is determined by the so-called sustainable growth rate formula ("SGR") and is designed to annually update reimbursement for all Medicare-reimbursed physician services. If the conversion factor increases, reimbursement for physician services increases; if the conversion factor decreases, reimbursement for physician services decreases. Under the SGR, the Centers for Medicare and Medicaid Services ("CMS") estimates an expenditure target for physician services in a given year. The expenditure target is determined by medical inflation, the gross domestic product, increases in the number of beneficiaries for fee-for-service Medicare and changes in law and regulation. If actual spending on physician services is greater than the expenditure target, physicians receive a negative update (i.e., the conversion factor is decreased, therefore decreasing payment for physician services). Since the Medicare reimbursement level for physician services is a component of Blue Cross' rate determination, this figure is critical to the Filing.

Blue Cross has proposed a physician fee schedule conversion factor of 1.5%. I believe that this is too high, given that CMS recently set this factor at -10.0%. Blue Cross arrived at the 1.5% figure by assuming that Congress will override CMS' current -10.0% conversion factor and by applying the final physician fee schedule conversion factor applicable to 2004 and 2005. Congress has overridden CMS' conversion factor for 2003 through 2007. For each of those years, CMS initially reduced payments to physicians. Ultimately, however, each of the

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[13] See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd, Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

CMS reductions was either increased from the previous year or was held steady:

YEAR	CMS REDUCTION	CONGRESSIONAL OVERRIDE
2003	-4.4%	1.6%
2004	-4.5%	1.5%
2005	-4.5%	1.5%
2006	-4.5%	0%
2007	-5.0%	0%

The assumption of a 1.5% conversion factor may not be unreasonable from an actuarial perspective. Yet, from a policy perspective, it is unreasonable to shift the risks of the uncertainties related to Congressional (in)action on the conversion factor on Plan 65 members. Rather, Blue Cross's surplus exists for the company to bear risks such as this. Such risk shifting by Blue Cross is not in the public interest and does not enhance the affordability of the Plan 65 products. For these reasons, and because Congress has applied a 0.0% change to the physician fee schedule conversion factor the last two years, Blue Cross must do so as well.

Trend Factors

The trends used by Blue Cross in its Plan 65 rate filing were reviewed by OHIC's consulting actuary, Mr. Charles C. DeWeese, FSA, MAAA. Blue Cross used standard methods and Mr. DeWeese found the results reasonable. Blue Cross has based its beginning cost value on 2006 experience, including claims paid through June 2007. Blue Cross then projected the 2006 claims to 2007, 2008 and 2009. Blue Cross's methods incorporate separate analyses of benefit changes mandated by Medicare and expected utilization changes. The original filing included an assumption of 1.5% increase in the physician fee schedule conversion. That assumption has been reduced to 0%. Therefore the trends Blue Cross is using in connection with this filing include primarily mandated benefit increase levels and Blue Cross's analysis of utilization increases. Blue Cross projects each benefit element separately. In aggregate, the average trends for combined benefit changes and utilization that are incorporate in the filing are:

- 4.2% for Select Plans and 4.5% for Medigap plans to project from 2006 to 2007
- 4.9% for Select Plans and 5.3% for Medigap plans to project from 2007 to 2008
- 4.5% for Select Plans and 5.1% for Medigap plans to project from 2008 to 2009

I accept Mr. DeWeese's analysis and find that Blue Cross' trend projections are reasonable.

Medical Loss Ratio

The percentage of revenues from health insurance premiums that pay for medical services (including both the actual expenses paid for medical services, plus some functions related to the provision of medical services) is referred to as the medical loss ratio ("MLR"). The amount is usually referred to by a ratio, such as 82%. An 82% MLR means that 82 cents of each premium dollar is spent on purchasing medical services.

Medigap products are required to have a minimum loss ratio of 65%. Blue Cross' expected loss ratios for this Filing meets the requirement:[14]

	PLAN A	PLAN B	PLAN C	PLAN L
Plan 65 Medigap	82.1%	105.8%	86.7%	--
Plan 65 Select	--	77.3%	85.6%	95.6%

Such expected loss ratios are consistent with past expected loss ratios. For example, expected loss ratios in the 2006 Medigap rate filing were:

	PLAN A	PLAN B	PLAN C	PLAN L
Plan 65 Medigap	82.9%	111.9%	89.8%	--
Plan 65 Select	--	79.9%	87.9%	78.8%

Finally, according to data provided by Blue Cross in its affordability update,[15] Blue Cross' Medigap loss ratios among the highest in the region.

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[14] Although the 65% minimum is the only requirement for Plan 65 loss ratios, further discussion of the Plan 65 loss ratios is appropriate for addressing the overall affordability of the Plan 65 products. It is in that context that Plan 65 loss ratios are examined.

[15] See section entitled "Affordability" below.

Contribution to Surplus

The proposed rate increase also includes a contribution to surplus, plus taxes on that contribution. The surplus contribution and federal income taxes account for 2.5% of the total rate increase sought in the Filing (2.0% for surplus and 0.5% for the federal income taxes on that component).[16] While surplus contributions (and the associated taxes) are generally an acceptable component of rate increases, this component is not appropriate for the proposed rate increase this year. Instead, I believe that a 1% contribution to surplus is more appropriate. I base this decision on two reasons. First, Blue Cross realized an exceptionally large net income for 2006, reporting nearly $50 million in net income in its 2006 annual financial statement. Second, Blue Cross' surplus level is at an all-time high. Blue Cross' 2006 earnings brought it close to its minimum adequate surplus level, as determined by an OHIC-commissioned study of adequate surplus levels for the state's major insurers. Because Blue Cross' surplus level is nearly at the level determined to be adequate, a 2% contribution to this surplus by Medigap subscribers members at this time is not in the consumer interest and it is not consistent with Blue Cross' mission as a publicly chartered, nonprofit charitable institution. Thus, the surplus contribution should be reduced by 1% (with a concurrent reduction in the federal tax amount).

Consumer Comments

We received only four consumer comments to the Filing, despite state-wide public notice of the proposed rate increase. All four comments were opposed to the rate increase and these comments were factored into my decision.[17]

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[16] An additional 1.1% of the total rate increase is attributable to the state premium tax.

[17] The relative lack of a public response cannot escape notice. Direct Pay filings typically draw 50 to 100 written comments. This Filing, which covers approximately 40% more subscribers than Direct Pay, typically draws only a handful of written comments.

Affordability

Blue Cross is generally required to meet affordability standards in its rate filings. Blue Cross addresses those standards through an annual affordability report and periodic updates submitted with its rate filings. The details of the affordability standards have been discussed extensively in previous filings.[18] In general, however, Blue Cross must demonstrate, among other things, that its trends are reasonable, it maintains control over its administrative costs, its spectrum of product choices is adequate and its rates are competitive with its competitors in the Rhode Island and regional markets.

With this Filing, Blue Cross submitted an affordability update and has generally satisfied this Office that it is taking steps to enhance the affordability of its products. Federal Medicare requirements place some limits on Blue Cross' ability to directly address the costs of Plan 65 claims, however, Plan 65's trends are appropriate, its administrative costs are reasonable, the spectrum of product Plan 65 choices is appropriate and the Plan 65 rates are competitive with the rates offered by other Rhode Island Medicare Supplement carriers.

We appreciate Blue Cross' ongoing efforts to address the affordability of its products and look forward to a fuller discussion of the issue of affordability with Blue Cross' next annual affordability report.

IV. CONCLUSION

Within the next five days, Blue Cross must recalculate its Plan 65 rates consistent with this Order and Decision and submit those recalculated rates to this Office.

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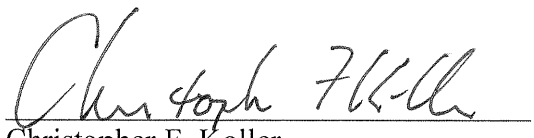
[18] See *In re Blue Cross & Blue Shield of Rhode Island Filing for New Non-Group Subscription Rates for Plan 65 Medigap Plans A, B and C and New Non-Group Subscription Rates for Plan 65 Select Plans B and C*, HIC No. 05-RH-01 (Oct. 28, 2005), available at www.dbr.state.ri.us/documents/divisions/healthinsurance/Ins_-_HIC_05-RH-01-Decision.pdf.

ENTERED AS AN ADMINISTRATIVE ORDER OF THE OFFICE OF THE OFFICE OF HEALTH INSURANCE COMMISSIONER THIS 15th DAY OF OCTOBER, 2007.



Christopher F. Koller
Commissioner
Office of the Health Insurance Commissioner

THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS DECISION MAY BE APPEALED UNDER THE ADMINISTRATIVE PROCEDURES ACT, RI GEN. LAWS § 42-23-1 *ET SEQ.*, TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.